Strategy Research Project

TOWARDS AN OPERATIONAL FORCE: HEALTH READINESS IN THE ARMY RESERVE

BY

LIEUTENANT COLONEL JOHN EDDY
United States Army Reserve

USAWC CLASS OF 2010

U.S. Army War College, Carlisle Barracks, PA 17013-5050

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE *(DD-MM-YYYY)*	**2. REPORT TYPE**	**3. DATES COVERED** *(From - To)*
24-03-2010	Strategy Research Project	

4. TITLE AND SUBTITLE

Towards an Operational Force: Health Readiness in the Army Reserve

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

Lieutenant Colonel John Eddy

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Dr Dallas Owens
Strategic Studies Institute

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

U.S. Army War College
122 Forbes Avenue
Carlisle, PA 17013

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT

Distribution A: Unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

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15. SUBJECT TERMS

Leadership, Transformation, Resourcing, Soldier Readiness Processing, Unit Status Reporting

16. SECURITY CLASSIFICATION OF:			**17. LIMITATION OF ABSTRACT**	**18. NUMBER OF PAGES**	**19a. NAME OF RESPONSIBLE PERSON**
a. REPORT	**b. ABSTRACT**	**c. THIS PAGE**			**19b. TELEPHONE NUMBER** *(include area code)*
UNCLASSIFED	UNCLASSIFED	UNCLASSIFED	UNLIMITED	28	

U.S.AWC STRATEGY RESEARCH PROJECT

TOWARDS AN OPERATIONAL FORCE: HEALTH READINESS IN THE ARMY RESERVE

by

Lieutenant Colonel John Eddy
United States Army Reserve

Dr Dallas Owens
Project Adviser

This SRP is submitted in partial fulfillment of the requirements of the Master of Strategic Studies Degree. The U.S. Army War College is accredited by the Commission on Higher Education of the Middle States Association of Colleges and Schools, 3624 Market Street, Philadelphia, PA 19104, (215) 662-5606. The Commission on Higher Education is an institutional accrediting agency recognized by the U.S. Secretary of Education and the Council for Higher Education Accreditation.

U.S. Army War College
CARLISLE BARRACKS, PENNSYLVANIA 17013

ABSTRACT

AUTHOR: Lieutenant Colonel John Eddy

TITLE: Towards an Operational Force: Health Readiness in the Army Reserve

FORMAT: Strategy Research Project

DATE: 24 March 2010 WORD COUNT: 5,872 PAGES: 28

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CLASSIFICATION: Unclassified

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TOWARDS AN OPERATIONAL FORCE:
HEALTH READINESS IN THE ARMY RESERVE

> Achieving the defense strategy's objectives requires vibrant National Guard and Reserves that are seamlessly integrated into the broader All-Volunteer Force. Prevailing in today's wars requires a Reserve Component that can serve in an operational capacity—available, trained, and equipped for predictable routine deployment. Preventing and deterring conflict will likely necessitate the continued use of some elements of the Reserve Component—especially those that possess high demand skill sets—in an operational capacity well into the future.[1]
>
> — Secretary of Defense Robert M. Gates
> Quadrennial Defense Review Report, February 2010

As the United States Army continues to conduct combat operations in support of the "Long War," the time has come to critically review current health readiness practices within the Army Reserve and recommend sourcing and systems changes to position it for transformation from a strategic to an operational reserve. This review needs to be accomplished applying the provisions outlined in Department of Defense Directive 1200.17 "Managing the Reserve Components as an Operational Force." As we look at the methods already being used, both Army Forces Generation (ARFORGEN) and the Army Transformation Plan, the information gathered will support a need to incorporate selected changes in Army Reserve culture, legislative initiatives, full-time manning, force structure, and the role and responsibilities of the command surgeon.

A Force Strained to the Breaking Point

As the United States enters the ninth year of sustained conflict, the stress and strain of combat has taken a tremendous toll on the armed forces, particularly the United States Army. The enduring requirement to provide military forces in support of combat operations in Afghanistan and Iraq has stretched the armed forces to the very limit of their abilities. This was in turn made all the more difficult by the growing demand

for forces to be used in support of Homeland Defense. With a set end-strength, and consistently large requirements for forces, the U.S. Army was facing a tremendous dilemma. How could they reasonable expect to continue to meet their mission requirements and yet still maintain a viable, healthy force?

The demographics for the U.S. Army in 2008 presented a sobering, if not disturbing picture of the available forces. At that particular moment in time the strength of the Army (both active and reserve component) was 1,097,050 Soldiers.[2] The Chief of Staff of the Army, General George W. Casey, provided a stark contrast to that end strength when he reported to the U.S. Congress "…that over 258,000 Soldiers are deployed fighting the war on terror and forward-stationed deterring our nation's adversaries."[3] Fully one-fourth to one-third of the total force was committed to either combat operations or preparation for deployment to combat operations at any given time.

The active component clearly could not provide that number; over half of them would be needed. In addition to the significant shortfalls within the operating force, there were similar issues with the generating force. Simply put, the services, particularly the Army, could not "generate" sufficient forces to meet demands. A recent example of recruiting paints a stark picture of the challenges that have faced the force throughout the past nine years.

> The propensity of our nation's youth to enlist in the military was at a historical low of 9 percent in June 2007. At the same time, DOD estimates that more than half the youth in the U.S. population between the ages of 17 and 24 do not meet the minimum requirements to enter military service. Approximately 22 percent of America's youth exceed the limits set for enlistees' body mass index. The military services will face extremely stiff competition from civilian employers seeking to recruit and retain the quality workforce required for the 21st century. Recruiting the all-volunteer

> force is more difficult and costly today than it has ever been. Only 79 percent of the new recruits entering the Army in fiscal year 2007 possessed a high school diploma (the DOD standard is 90 percent), and the Army approved more waivers for candidates with a criminal history (10 percent of all recruits) than it has done in years past.[4]

It is abundantly clear that the traditional method for generating forces is simply unsustainable. There were insufficient forces available to face the challenges expected in the near future. There had to be a better, more efficient means to use the scarce forces available.

A Way Through the Wilderness – Army Forces Generation

In recognition of this growing strain, the Department of the Army (DA) began to employ a forward thinking process to mitigate and possibly minimize the impact of multiple deployments. General Charles C. Campbell in an article written for the Association of the United States Army in June of 2009, noted that the Army clearly recognized it was in an "…era of persistent conflict.." and that "…the global demand for land forces exceeds the available supply."[5] Something had to be done, and it had to be done quickly.

A better system was developed and implemented. Known as Army Forces Generation, or ARFORGEN, it is intended to provide commanders at all levels a degree of predictability as they prepare for future deployments. ARFORGEN was initiated by a memorandum from then Secretary of Defense Donald H. Rumsfeld in which he directed the senior service leaders to re-visit the issue of proper balance of forces between the active and reserve components.[6] Specifically, he wanted further refinement of the process for requesting forces in order to develop long term solutions for the current conflicts in Iraq and Afghanistan. This request for additional information laid the ground

work for key elements of the Army Campaign Plan which incorporated the process that would become known as ARFORGEN.

General Campbell noted “In 2005, the Chief of Staff of the Army approved the ARFORGEN model for concept development. A year later, the Secretary of the Army approved the implementation of ARFORGEN. Since then, ARFORGEN has proved to be a flexible force generation construct.”[7] As discussed in the most recent Land Warfare Papers, “Under ARFORGEN, unit readiness is managed on a cyclical basis, with [reserve component] units ready for deployment one year out of five as a planning target.”[8] The intent was to provide “…predictability for Soldiers, Families, communities, and employers” and to synchronize “… deployments with the preparations of our next-to-deploy forces and the reset of recently deployed forces.”[9]

The adoption of this model moved the Army beyond the legacy system of Joint Operations Planning and Execution System (JOPES) and transitioned the force to what would become known as the Global Force Management Allocation Process.[10] Though an improvement, this model alone cannot solve the problems faced by the current force structure; more innovation is needed.

Transformation – Preparing the Army for the Future

In the late 1990s the Army recognized that there was a growing need to transform the force to make it more agile and lethal. In November of 2001 the Government Accounting Office (GAO) released a report that noted that “The Army has begun to transform itself from a Cold War-oriented force into a more rapidly deployable and responsive force better able to meet the diverse defense challenges of the future.” However, the same report stated “The far-reaching organizational and operational changes that the Army plans will affect virtually every element of the Army and take

decades to implement."[11] Considering the context in which the report was released, the comment that it would "…take decades to implement" was an understatement. The devastating attacks on New York City and Washington DC were still uppermost in most minds as the Army leadership began the ambitious process of transforming the force.

The Department of Defense provided a press release in December of 2001 that provided a glimpse into this ambitious effort that would begin with the Headquarters, Department of the Army and work its way throughout the force. It stated the transformation "…was to streamline decision-making, achieve greater unity of effort within the headquarters, remove unnecessary layers in the organization, and gain greater control over resource management."[12] To further explain the changes, General Eric K. Shinseki commented "This alignment creates a more effective and efficient headquarters and enables us to increase our momentum in achieving the Objective Force this decade."[13]

The Army Transformation Campaign Plan eventually identified four imperatives for success;[14]

- Sustain our Soldiers, Families, and Army Civilians;
- Prepare our Soldiers for success in the current conflict;
- Reset the force expeditiously for future contingencies; and
- Transform the Army to meet the demands of the 21st century

The centerpiece for this effort would become the individual Soldier and the mindset joint and expeditionary. The intent was to move from an Army based around large, powerful, fixed organizations (e.g. divisions) to an Army designed around smaller, more self-contained organizations (e.g. brigades). Thus, the modular construct would

give the ground force commander greater flexibility of employment, increase the overall capability of the combat force, and thus require fewer Soldiers to perform a mission.

The Army clearly had a plan to more effectively use the forces currently available and meet future requirements by properly “balancing” the force. This would further support Secretary of Defense Rumsfeld when he directed the service chiefs to review the proper mixture of active and reserve component forces.[15] The remaining requirement was to develop a method to capitalize on the reserve component. They represented a resource that had not been fully utilized.

The Need for an Operational Reserve

As a parallel process to transformation efforts, the Commission on the National Guard and Reserves (CNGR) was established by the Ronald Reagan National Defense Authorization Act for Fiscal Year 2005.[16] The CNGR mandate was clearly outlined in the introduction to their final report;

> Through its enabling statute, Congress tasked this Commission to report on the roles and missions of the reserve components; on how their capabilities may be best used to achieve national security objectives, including homeland defense; on their compensation and benefits and on the effects of possible changes in these areas on military careers, readiness, recruitment, and retention; on traditional and alternative career paths; on their policies and funding for training and readiness, including medical and personal readiness; on the adequacy of funding for their equipment and personnel; and on their organization, structure, and overall funding.[17]

Though tremendous effort and planning had gone into the development of the Army Transformation Campaign Plan, a key element had been somewhat neglected, the reserve component. They were still not viewed as an equal partner in the transformation process. There was no distinct, developed plan to further enhance and develop their capability as a member of the total force.

The release of the report by the CNGR, *Transforming the National Guard and Reserves into a 21st Century Operational Force*, had a marked impact on the plan. It brought a degree of clarity to the effort, ensuring that the reserve component was seen as a vital element that was absolutely essential for future success. As noted by the commission,

> In reviewing the past several decades of heavy use of the reserve components… the Commission has found indisputable and overwhelming evidence of the need for change. Policymakers and the military must break with outdated policies and processes and implement fundamental, thorough reforms. Many of today's profound challenges to the National Guard and Reserves will persist…. The need for major reforms is urgent regardless of the outcome of current conflicts or the political turmoil surrounding them. The Commission believes the nation must look past the immediate and compelling challenges raised by these conflicts and focus on the long-term future of the National Guard and Reserves and on the United States' enduring national security interests.[18]

The commission left no doubt in its findings. It was time for fundamental change within the Department of Defense.

The final report was exceptionally thorough and comprehensive, presenting six major conclusions and 95 recommendations, supported in turn by 163 findings.[19] The conclusions provided superb insight and breadth of understanding into the contemporary issues of the Army Reserve and the Army National Guard. They were;

- *Creating a Sustainable Operational Reserve*
- *Enhancing the Defense Department's Role in the Homeland*
- *Creating a Continuum of Service: Personnel Management for an Integrated Total Force*
- *Developing a Ready, Capable, and Available Operational Reserve*
- *Supporting Service Members, Families, and Employers*

- *Reforming the Organizations and Institutions That Support an Operational Reserve*[20]

These six major conclusions provided clarity to the effort of "operationalizing" the Army Reserve and Army National Guard, providing the Department of the Army a framework to apply to their Army Transformation Campaign Plan. However, setting aside the regulatory and legal aspects to the recommendations, there remain issues that need to be addressed from a structural, cultural and resources standpoint.

A Critical Conclusion – Developing a Ready, Capable, and Available Operational Reserve

Though each of the six conclusions has merit, one in particular stands out as the most daunting challenge for leaders within the Department of the Army and the Army Reserve. A key tenet of this evolving paradigm is the need for sustained, measurable readiness. As outlined by the commission, readiness is further defined by the fact that "An operational reserve component requires a higher standard of readiness than does today's Ready Reserve, for a greater duration, with less time to achieve readiness goals between deployments."[21] This finding recognizes relying upon a total volunteer force means there is a corresponding reliance on the reserve component to conduct operations. It also acknowledges a portion of the force, a "bill payer," pays the price for readiness for the rest of the force. An "expeditionary" Army cannot wait for the reserve component, particularly the Army Reserve, to complete the necessary training and meet the readiness standards necessary for deployment. A portion of the force has to be constantly ready, and relevant, at a moment's notice. The conclusion is inescapable; the "strategic reserve" culture must change.

Per the finding, several areas require change to actually create a "…Ready, Capable, and Available Operational Reserve." First and foremost among these 95 recommendations was the need to improve personnel management, particularly in the area of readiness. Though the most recent experiences in the Gulf War had been somewhat troubling, no major efforts had been made to address the readiness shortfalls of the legacy, "strategic reserve." Volumes of pertinent data have been collected, reviewed and analyzed, but precious little has been done to develop a systematic means of addressing readiness issues. In instance after instance, units have reported to mobilization stations with personnel that were not "ready" for deployment into the theater of operations. This in turn created deployment lags and played havoc with the operational plans of the supported commanders as they awaited the arrival of critical Army Reserve units. Despite efforts over the years to address this issue, readiness problems continued unabated into Operation Enduring Freedom/Operation Iraqi Freedom.

The commission identified readiness issues and presented recommendations (29 through 51) to address them.[22] These recommendations took a "holistic" approach to the issues, recognizing that the solution is neither simple nor straightforward. In order to develop a sustainable operational reserve, a systematic approach is necessary. In a broad sense, these recommendations were divided into six supporting categories; Personnel, Individual Medical Readiness, Full-Time Support, Training, Equipment and Supplies, and Access to the Reserve Components. Each of these sub-categories provides critical insight into the issues that face the leadership of the Army Reserve. They succinctly describe the problem and provide various means to address them. For

purposes of this paper, we will focus on a critical, yet under-appreciated, aspect of the recommendations, individual medical readiness.

Individual Medical Readiness – The Key to Success

Though the senior leadership of the Army recognized the need for improved individual medical readiness, it was, unfortunately, very late to provide clear guidance to the entire force as to how to achieve it. Few would disagree with the findings of the commission regarding potential failure when there are many inadequacies in determining and administering deployment health. Simply stated, "Not meeting medical and dental readiness standards may result in a reservist's failure to deploy, lengthy delays during the mobilization process, or an increased risk of injury, illness, or fatality."[23] However, prior to 2002 few reserve component commanders could adequately define the medical and dental health standards necessary for deployment. Units and commanders did not clearly have an answer to the question, "What constitutes success?"

The methods to outline and enforce standards for individual medical readiness were haphazard at best prior to 2001. The only published standard available prior to 2001, Army Regulation 40-501, Standards of Medical Fitness, paid scant attention to the codification of deployment health and what could be deemed "success." Previous editions gave the most rudimentary of guidance regarding the minimum standards for deployment. Conversely, it provided an abundance of guidance regarding minimum medical standards for retention and special duties status. As it became evident that the "War on Terror" would be a long conflict, the Army G-1 and the Office of the Surgeon General rectified the situation and published updated guidance to ensure clarity of

means and methods. This was in turn further assisted by the publishing of Department of Defense Instruction 6025.19, *Individual Medical Readiness* in January of 2006.

Individual Medical Readiness – A Clear Standard for Success

In addition to a well developed system for requesting and assigning forces, in 2006 the Department of Defense (DoD) finally provided succinct guidance to DA regarding medical readiness requirements. The provisions of Department of Defense Instruction 6025.19, *Individual Medical Readiness*, set standards for success that are now abundantly clear. The instructions to the Secretaries of the Military Departments are that "the minimum goal for overall medical readiness is more than 75% of Service members FMR, with the ideal goal being 100%."[24]

With a method to now formally "codify" success, the individual medical readiness indicators were divided into six categories; *Periodic Health Assessment (PHA)*, *No Deployment-limiting Conditions*, *Dental Readiness*, *Immunization Status*, *Medical Readiness Laboratory Tests*, and *Individual Medical Equipment*.[25] Based upon these categories for individual medical readiness, a service member can now be reported, based upon their availability for deployment, using one of four categories of readiness; *Fully medically ready*, *Partially medically ready*, *Not medically ready*, or *Medical readiness indeterminate*.[26] Though these two sets of categories would be later updated, they served as an excellent start for resolving the issue of individual medical readiness.

In addition to the Department of Defense provisions, the Department of the Army G-1 also provides the following guidance to Army Reserve commanders;

> The Army National Guard (ARNG) and U.S. Army Reserve Command (USARC) are responsible for medically screening their forces prior to mobilization. Soldiers who fail to meet medical retention standards IAW AR 40-501, Chapter 3 will not be sent to the mobilization station. ARNG

> and USAR commanders will certify that pre-mobilization medical/dental screening has been accomplished.[27]

The guidelines contained in the Department of the Army Personnel Policy Guidance for Overseas Contingency Operations (14 October 2009), Chapter 7 (Medical) built upon the basic standards found in AR 40-501, providing theater specific guidance on minimum standards of medical fitness based upon medical care available in theater and ongoing evaluation of deployed health care issues.

Recognizing the need for a systemic approach, the Army Reserve, under the auspices of the Assistant Secretary of Defense for Health Affairs, implemented a comprehensive health fitness program for their Soldiers in order to meet the standards established by DA and DoD documents. The Reserve Health Readiness Program (RHRP) is managed by the DoD under a contract with Logistics Health Incorporated (LHI). The main objective of the program "…is to ensure the health readiness of Services Members comprising the Armed Forces. The program does this by providing the necessary medical and dental standards and requirements essential in maintaining a deployable force."[28]

Despite the sound methodology that has been instituted within the Department of the Army, the clear guidance regarding the standards for health readiness, and the availability of the resources necessary to meet these standards, Army Reserve units continue to report to mobilization station with Soldiers who are not fully medically ready. The DoD limitation on the length of involuntary mobilization is 400 days; each day spent at the mobilization station is a potential lost day in theater. An even more serious potential issue is the possibility that the Soldier will not meet individual readiness standards and will be released from active duty (REFRAD). This could necessitate a

last minute cross-leveling of a Soldier to ensure that the unit meets deployment guidelines for strength management. The question is, “Why do we still face these readiness challenges?”

An understanding of the mobilization process would help to establish a framework for the discussion. As noted in FM 100-17, “The five phases of mobilization are planning, alert, home station (HS), mobilization station, and port of embarkation (POE).”[29] It is during the planning, alert, and home station phases that the majority of health readiness tasks are completed. It is at this point in the mobilization process the commander has the necessary resources allocated to prepare the unit for mobilization and eventual deployment. Yet it is precisely during this time these tasks are not being accomplished.

Individual Medical Readiness – A Practical Look at Structural and Cultural Shortfalls

When a careful examination of the medical readiness factors is made, there are actually many reasons for the shortfalls in meeting standards, some that are readily observable, and some that are not. First and foremost, there are tremendous issues with the assignment and utilization of organic health readiness personnel within the Army Reserve. Part of this can be attributed to force structure decisions, partly to manning of units, and partly to recruiting. A critical issue is that the Army Reserve continues to struggle with the concept of appointing and empowering a “command surgeon” who is responsible for monitoring, reporting, and advising on health readiness within the command. In Army doctrine, Force Health Protection is the exclusive purview of the command surgeon. As noted in Field Manual 4-02 (Force Health Protection in a Global Environment), “At all levels of command, a command surgeon is designated. This AMEDD officer is a special staff officer charged with planning for and monitoring

the execution of the HSS mission."[30] In addition, the command surgeon is the principal staff officer responsible for "Advising the commander on the health of the command."[31]

However, more often than not, major subordinate commands within the Army Reserve either do not have a command surgeon authorized or assigned. Hence, the responsibility for this critical element of readiness falls to available full time manning staff, in general, personnel staff (G-1/S-1). This is an unsatisfactory state of affairs as the personnel staff are called upon to provide critical information on the individual medical readiness of a Soldier for which they do not have the requisite training or experience to render an informed opinion. They are simply unable to interpret the data available to them.

Recent innovations in information technology have been implemented across DoD to ensure the security and validity of medical data. However, in the process of implementing these changes, DoD failed to ensure that LHI would continue to have access to necessary information provided by units. This failure created tremendous issues as units were required to submit paper records for input rather than completing necessary actions on-line. Hence, when coupled with the fact that there is generally no one medically qualified to review the data at the unit level, along with a degree of difficulty in updating and maintaining the available data, the conditions are set for a "perfect storm." Critical data collected is lost and is not available to help the commander make informed decisions on the individual medical readiness of unit members.

Another key element of the failure has been a lack of accountability in the readiness reporting process. As noted by the commission;

> The service Secretary and Chief of each service are responsible for the readiness of both their active and reserve components. All too often, the

> Commission has found this statutory responsibility to be so diluted through delegation that those with Title 10 responsibility for reserve component readiness do not monitor and report on that readiness.
>
> Complicating any effort to assess the readiness of the reserve components is the lack of uniform reporting standards among the services. Moreover, their reports do not include information on full-time manning levels, on individual medical readiness, or on the readiness of the National Guard and Reserves to perform homeland missions.[32]

Simply stated, there was no "early warning" system that ensured accurate, up to date information was maintained on the unit prior to it reporting to mobilization station. Again, the information is not being reviewed by a command surgeon but is simply being transmitted without evaluation "as is" to higher headquarters, with little to no analysis or careful thought as to the "meaning" of the information.

Another issue is periodic changes and updates to health readiness requirements. Though the combatant command tries to ensure the requirements are relevant to the mission and the area of operations and are published in a timely fashion, there continues to be an information lag from the forward deployed areas to the force providers. Couple that with the fact that the "receptor" at the command level is more often than not personnel staff (e.g. G-1/S-1) rather than a clinician (e.g. command surgeon) and you have a recipe for failure. Again, the individual given the mission to review the health readiness requirement updates simply does not have the acumen or expertise necessary to understand its importance and ensure that it is transmitted in a timely fashion to subordinate units.

Balancing the factors listed above, another key element contributing to the failure to meet readiness standards can be found in the Army's organizational culture in general and the Army Reserve in particular. As noted by Carl Builder in his seminal work, "The Masks of War", the Army has a specific service identity. He states that "The

Army's identity as the nation's "handyman" or loyal military servant is a fair characterization of most of its history."[33] He further comments;

> What is the Army? It is first and foremost, the nation's obedient and loyal military servant. It takes pride in being the keeper of the essential skills of war that must be infused into the citizenry when they are called upon to fight.[34]

This culture is a significant reason that the Army has been successful throughout the history of the nation. The concept of being a "servant" has served the Army well, allowing it to persevere in the most difficult of times. However, this commitment to service can also lead to a certain degree of fatalism when faced with seemingly insurmountable difficulties and limited resources. A "servant" will rarely ask his "master" for assistance when they need help. Instead, they will rely on a "can do" mentality to guide their actions.

This cultural artifact can be most clearly seen in the results of a recent unit mobilization. The following vignette provides a picture of how the other factors, when coupled with issues of an organization's culture (and even sub-culture) can lead to challenges which make a difficult process even more trying. How a commander and his or her staff coordinate their preparations for mobilization speaks volumes regarding this cultural phenomenon.

An Army Reserve unit was scheduled to mobilize in 2009 and directed by an operation order from U.S. Army Reserve Command (USARC) to address health readiness shortfalls that had been identified in advance.[35] The unit needed to correct significant medical readiness deficiencies in order to comply with theater guidance and DA G-1 standards for deployment. During the course of five months, from alert to reporting to mobilization station, the unit commander and staff engaged in a series of "e-

mail battles" with the USARC Command Surgeon regarding standards for health readiness. This test of wills continued until the day the unit reported to mobilization station. Even though the standards were clearly published, a staff assistant visit had been conducted, information was available through the Medical Protection System (MEDPROS) [36], and the scheduling had been made for Soldier Readiness Processing through the Reserve Health Readiness Program[37], the unit still reported to the mobilization station with significant health readiness shortfalls. What cultural trait was at work?

In his book "Who Says Elephants Can't Dance?" Louis Gerstner offers an interesting observation about his experiences at IBM in regards to culture. He states;

> What you can do is create the conditions for transformation. You can provide incentives. You can define the marketplace realities and goals. But then you have to trust. In fact, in the end, management doesn't change culture. Management invites the workforce itself to change culture.[38]

Within this quote are the seeds for the cultural issue that the Army Reserve is facing. Just as IBM had thrived and succeeded for many years prior to his arrival, so has the Army Reserve. However, the events of September 11th signaled a tremendous shift in the paradigm for the Army Reserve, a shift that was not fully understood. A mindset had to change.

The old cultural norm (mindset) was that, except for a few "high priority units", "all readiness issues will be resolved at the mobilization station." With the demands of today's Army this observation seems counterintuitive, but in fact encapsulates the Army Reserve's cultural context regarding readiness preparation during planning, alert, and pre-mobilization stages. Full time support manning does not need to be overly concerned with readiness requirements because the unit can report to mobilization

station and expect the power projection platform (PPP) to perform tasks that should have been completed at the unit's home station. Because the pressure is on to ensure units timely deployments, a "can do" attitude prevails at the PPP and a plan to address readiness issues is cobbled together and executed with available resources.

The same can be said for the role of the command surgeon. Though the title may be given to a qualified individual, they are not called upon to fulfill the responsibilities of the role. Why? Because "all of the difficult readiness issues will be resolved at the mobilization station." The belief is often further supported by the lack of resources made available (funding, additional man days, temporary augmentation for full time manning) to resolve readiness issues prior to mobilization. Hence, this mantra is repeated time and again as units continue to make the same mistakes. Again, a commander does not "…need to be familiar with the information found in MEDPROS." A command surgeon "…is not necessary." Example after example can be given, all ending with the same result – a unit arrives at the PPP with some, if not many, of its members not medically prepared for deployment.

Individual Medical Readiness – A Way Ahead

So what is the answer? There are actually many answers, but I will focus on only a few. Some of the cultural issues will simply take time. As officers and noncommissioned officers are promoted within the Army Reserve, they will carry forward their own experiences in support of the current conflict and will begin to eliminate the dysfunctional aspects of their culture. The USARC can also continue to enact support practices that encourage change, in some instances by means of incentives (awards and recognition), and in others by punitive measures (evaluations, letters of concern or reprimand and possible relief for cause). Planning conferences and

staff assistance visits provide mechanisms for a commander to identify shortfalls and address them.

In addition, the CNGR recommends sweeping legislative changes that will address the haphazard, incremental changes that have already been put in place by necessity. It notes that the situation with the Army Reserve has reached a crisis point and must be addressed by the appropriate legislative bodies;

> The Commission believes that backing into such a far-reaching decision [an operational reserve] is a mistake, because it is not clear that the public or its elected representatives stand behind this new concept. Major changes in the roles and missions of the reserve components must be examined, discussed, and accepted by the public and Congress if they are to succeed. Our analysis shows that there is much to debate, and the debate is overdue.[39]

It is interesting to note the second CNGR report published on 1 March 2007 recommended "Congress should establish a bipartisan Council of Governors…" to "…meet and advise the Secretary of Defense, the Secretary of Homeland Security, and the White House Homeland Security Council…"[40] Yet the first meeting of this council was held on 20 February 2010, nearly three years after the recommendation was given. Another change that needs to be addressed is full time support manning. This is a key recommendation from the commission that still has not been adequately addressed. The AGR full time manning facts are simple;

- Army Reserve AGR authorizations (15,870 personnel) are maintained at 74% compared to the level of requirement (21,322 personnel)
- Army Reserve AGR authorizations (15,870 personnel) comprise only 7% of the Army Reserve force (205,000)[41]

The Army Reserve cannot continue to execute a post September 11th mission with pre September 11th resources. It must be recognized that if the Army Reserve is to

transition to an operational force it must have the full time manning necessary to make the change. As summarized by the commission in recommendations 35 to 39,

> In the Army, funding for full-time support has not been sufficient. In fact, the Army does not have a reliable process for determining full-time support requirements in its reserve components. But it is clear that in particular, small units (equivalent to company-size and below) have not received adequate FTS personnel. The provision of full-time support is an opportunity for the Army to more fully integrate its active and reserve components into a total force.[42]

There have been multiple analyses conducted and all support the need for a greater number of authorized and assigned full time support personnel. However, this view is not shared by all of DoD – there is significant resistance to funding at even a pre- 9-11 requirement and even more so to increasing these requirements to address growing challenges. There is also further disagreement about what actually the nature of the "full time" force should even be – AGR RC versus AC, civilian versus AGR RC, etc. These issues only serve to further complicate a difficult situation. As an initial recommendation, the Army Reserve should be funded to 90% of their AGR authorizations in order to provide the necessary resources to improve readiness.

Finally, in order for there to be success, the role of the command surgeon must be emphasized down to the battalion and brigade level within the US Army Reserve. This emphasis must be based upon long overdue changes to force structure that provide each commander with a staff officer that is capable of providing concise and expert advice on the health of the command. The position of command surgeon should be incorporated into commands both in terms of full time manning (clinical and health readiness coordinators) and the creation of part time billets (60A – Command Surgeon). These individuals are the final, yet most vital, element to ensuring the success of the individual medical readiness mission. They alone possess the degree of expertise

necessary to warrant being given the mission of “advising the commander on the health of the command.”[43]

Endnotes

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